Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# CMS OVERSIGHT OF SHORT-TERM ACUTE CARE NONACCREDITED HOSPITALS

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Inspector General

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## OBJECTIVE

To assess the extent to which the frequency of short-term acute care nonaccredited hospital surveys has changed since the 1999 Office of Inspector General (OIG) reports on hospital oversight.

## BACKGROUND

This report serves as a followup to a series of reports released by OIG in 1999 on the external review of quality oversight in hospitals. One of those reports found that a large and growing number of short-term acute care nonaccredited hospitals had not been surveyed within 3 years. In its response, the Centers for Medicare & Medicaid Services (CMS) committed to surveying all nonaccredited hospitals with the same frequency as accredited hospitals, every 3 years, and to obtaining the funds necessary to establish a more frequent survey cycle.

To receive Medicare reimbursement, hospitals must demonstrate to CMS their initial and ongoing ability to meet a set of minimum quality and safety standards, referred to as conditions of participation. Hospitals can do this in two ways: by paying for accreditation or by receiving certification from the State survey and certification agencies at no charge. While about 83 percent of hospitals choose accreditation, about 17 percent of the nation's 4,020 hospitals are nonaccredited. CMS oversees nonaccredited hospitals through routine certification surveys and complaint (allegation) surveys conducted by the States. In this report, we focused on short-term acute care nonaccredited hospitals, which constitute 72 percent of all nonaccredited hospitals.

We based our assessment of survey and complaint data on two sources of data: the Online Survey Certification and Reporting System data and CMS's State Survey and Certification Budget Call Letters. The Budget Call Letters establish the priority for survey activities for all types of facilities for the States. The States use the information to prepare their yearly budgets.

## FINDINGS

**In 2003, States surveyed 79 percent of short-term acute care nonaccredited hospitals within 3 years compared to 50 percent in 1997.** The percent of short-term acute care nonaccredited hospitals surveyed within 3 years grew from 49 percent in 2001 to 62 percent in 2002 and 79 percent in 2003.

**However, the national annual survey rate is too low to sustain this progress.** The national annual survey rate reflects the number of short-term acute care nonaccredited hospitals surveyed each year divided by the total number of such hospitals in all 50 States in each fiscal year. To ensure that all short-term acute care nonaccredited hospitals are surveyed once every 3 years, at least 33 percent of hospitals should be surveyed each year over a 3-year period, assuming that the number of hospitals does not change and no hospital is surveyed more than once. In 2001, States surveyed 25 percent of short-term acute care nonaccredited hospitals nationally. The national annual survey rate grew to 28 percent in 2002. However, States surveyed only 21 percent of such hospitals in 2003. Several factors contributed to these declines in surveys for nonaccredited hospitals:

**Conversions to critical access hospitals necessitated additional surveys by State agencies.** The number of nonaccredited hospitals decreased from 1,361 to 640 between 1997 and 2003. During this period, many nonaccredited hospitals converted to critical access hospitals. Between 2000 and 2003, the number of critical access hospitals increased from 318 to 855. These conversions add more surveys to States' already full workload.

**Other surveys take priority over nonaccredited hospital surveys.** Other survey priorities can limit the attention and resources that States can spend on surveys of nonaccredited hospitals. Complaint surveys, which are limited to investigating the conditions of participation in question, require an onsite survey at both accredited and nonaccredited hospitals. These surveys grew 79 percent, from 2,079 to 3,721 between 1997 and 2003. In addition, completing surveys at facilities with legislatively mandated survey cycles, such as nursing homes and home health agencies, is a higher priority than performing surveys at nonaccredited hospitals.

**Budget Call Letter Language.** CMS committed to establishing a more frequent survey cycle for nonaccredited hospitals so that they would be surveyed with the same frequency as that established by the Joint Commission on Accreditation of Healthcare Organizations for accredited hospitals. Rather than establishing a 3-year survey cycle for nonaccredited hospitals, the CMS Budget Call Letter calls for States to survey 33 percent of their nonaccredited hospitals annually. Though on the surface it might appear that this language is equivalent to a 3-year survey cycle, this is not the case. By repeatedly

surveying some hospitals and not surveying others, which may be necessary to ensure safety and quality, States can consistently meet the 33 percent annual survey rate for their nonaccredited hospitals, but not survey all nonaccredited hospitals within 3 years.

## SUMMARY

Certification and complaint surveys remain the principal way that CMS and State agencies can ascertain whether nonaccredited hospitals meet Federal health, safety, and program standards. While the percent of short-term acute care nonaccredited hospitals surveyed within 3 years has increased, the national annual survey rate has dropped and is now too low to sustain this progress. To ensure that all short-term acute care nonaccredited hospitals are surveyed once every 3 years, at least 33 percent of hospitals should be surveyed each year over a 3-year period, assuming that the number of hospitals does not change and no hospital is surveyed more than once.

## AGENCY COMMENTS

CMS agreed that recent survey rates make sustained improvement in the percent of short-term acute care nonaccredited hospitals surveyed within 3 years uncertain. It further noted that it has additional survey responsibilities and that resources are limited.

CMS identified adjustments it will make in response to our report. First, it will lower the priority of its earlier commitment to survey nonaccredited hospitals once every 3 years. It will also create a new, higher priority goal of surveying nonaccredited hospitals an average of every 4.5 years. Further, it will require States to target certain hospitals that are more likely to have systemic quality problems for more frequent surveys. Finally, it will add a performance standard for States to ensure that the top priority survey frequencies are met. For CMS's complete comments, see page 11 of this report.

## OIG RESPONSE

We are pleased that CMS agrees with our summary that although the percentage of short-term acute care nonaccredited hospitals surveyed within 3 years has improved, recent national annual survey rates raise concern that the improvement may not be sustainable. However, CMS also proposes changes to the survey commitment it made in response to OIG's previous report (that it survey nonaccredited hospitals every

3 years, which is the same frequency as that of the Joint Commission on Accreditation of Healthcare Organizations).

We acknowledge that CMS faces resource limitations. However, we remain concerned that its adjustments could result in some nonaccredited hospitals operating without a survey for considerable lengths of time. Because CMS proposes an *average* of 4.5 years between surveys, by definition the gap between surveys at some nonaccredited hospitals will exceed that length of time, and some could exceed it by a considerable number of years.

At the same time, we appreciate the role that targeting some hospitals for more frequent surveys can serve in protecting Medicare beneficiaries. Furthermore, we also appreciate CMS's addition of performance standards for States.

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# INTRODUCTION

## OBJECTIVE

To assess the extent to which the frequency of short-term acute care nonaccredited hospital surveys has changed since the 1999 Office of Inspector General (OIG) reports on hospital oversight.

## BACKGROUND

In 1999, OIG released a series of reports on the external review of quality oversight in hospitals. This report serves as a followup to one of the reports in that series entitled "The External Review of Hospital Quality: The Role of Medicare Certification," OEI-01-97-00052. Since that series, increasing attention has been paid to the importance of assuring safety and quality in hospital care. In 1999, the Institute of Medicine released the report, "To Err is Human," in which it estimated that as many as 98,000 patients die each year from medical errors that occur in hospitals. A study released in 2003 found that medical injuries that occurred during hospitalization pose a significant threat to length of stay and increased medical expenses and mortality for patients.[1] In addition, a 2002 survey of hospital risk managers reports that preventable harm is not consistently and thoroughly disclosed to patients.[2]

### Medicare Certification and Hospital Accreditation

For hospitals to receive Medicare reimbursement, they must demonstrate to the Centers for Medicare & Medicaid Services (CMS) their initial and ongoing ability to meet a set of minimum quality and safety standards, referred to as the conditions of participation.[3] Hospitals can choose one of two ways to do this. They can either pay for accreditation by the Joint Commission on Accreditation of Healthcare Organizations (hereafter referred to as Joint Commission) or the American Osteopathic Association, or they can receive certification from the State survey and certification agencies at no charge.[4] Accrediting organizations survey hospitals every 3 years.

While about 83 percent of the nation's 4,020 acute care hospitals choose accreditation, the remaining 17 percent are certified rather than accredited. These hospitals are commonly referred to as nonaccredited hospitals. Nonaccredited hospitals play an important role in the health care system by providing care in areas that are often rural and remote.[5] Nonaccredited hospitals demonstrate their compliance with conditions of participation to CMS by receiving Medicare certification through

surveys that State agencies conduct under CMS funding and guidelines. CMS does not charge hospitals for these surveys.[6]

### Medicare Certification and Complaint Surveys

Certification and complaint surveys are CMS's and the State agencies' main tools to ascertain whether nonaccredited hospitals meet Federal health, safety, and program standards. Because private accreditation organizations do not oversee nonaccredited hospitals, CMS relies on information from State surveys to determine that these hospitals are qualified to serve Medicare patients. State agencies conduct these surveys on behalf of CMS according to procedures outlined in CMS's State Operations Manual.[7]

State agencies use complaint (allegation) surveys as another mechanism to oversee hospitals. State agencies are responsible for investigating complaints at both accredited and nonaccredited hospitals. Complaints may originate from a variety of sources including in person, by phone, in writing, or from newspaper or magazine articles. Though certification surveys are always announced, complaint surveys are unannounced. Complaint surveys do not substitute for a standard survey. These surveys cover only conditions of participation related to the complaint, although surveyors may expand the scope if they find other unmet conditions during their focused investigation.[8]

### CMS State Survey and Certification Budget Call Letter

Each year CMS establishes the priority for survey and certification activities for all types of facilities in its Budget Call Letter to the State survey agencies. The States use that information to prepare their yearly budget requests for survey and certification activities. Starting with the 2001 Budget Call Letter, CMS increased the guidelines for the percent of all nonaccredited hospitals that it expects States to survey annually to 33 percent, up from 15 percent in 1997 and 11 percent in 2000.

### Prior Work

In 1999, OIG released a series of reports that identified strengths and limitations in CMS's oversight of both accredited and nonaccredited hospitals. One of these reports, which focused on short-term acute care nonaccredited hospital certification, found that CMS and State agencies placed a low priority on the large and growing backlog of nonaccredited hospitals that had not been surveyed within 3 years. Although the Joint Commission had established a period of 3 years between surveys as the industry standard for accredited hospitals, CMS did not hold

nonaccredited hospitals to that standard. In 1997, 50 percent of short-term acute care nonaccredited hospitals had not been surveyed within 3 years. At the time, CMS funded hospital survey activity at a level that would allow for surveying nonaccredited hospitals once every 10 years. In contrast, the funding for home health agencies allowed for surveying facilities once every 18 months. The reports found that most of CMS's hospital survey budget was dedicated to investigations of complaints and serious incidents, which CMS considered a priority. The reports also found that CMS did little to hold the State agencies accountable for their performance in overseeing hospitals.

Based on this assessment, OIG recommended that CMS determine the appropriate minimum cycle for conducting certification surveys of nonaccredited hospitals. In a written response to the report, CMS committed to surveying all nonaccredited hospitals as frequently as accredited hospitals (every 3 years) as well as to obtaining the funds necessary to establish a more frequent survey cycle.

## METHODOLOGY

We based our analysis of certification and complaint surveys for nonaccredited hospitals on two sources of data: the Online Survey Certification and Reporting System (OSCAR) data and CMS's State Survey and Certification Budget Call Letters.

**OSCAR Data.** We analyzed OSCAR data, which compiles the results of certification as well as complaint surveys for nonaccredited hospitals. Our survey analysis is based on data downloaded in July 2004. The OSCAR system, at any given time, only contains survey information for each hospital's four most recently conducted certification surveys. Data are not retained for surveys conducted before the most recent four surveys for each hospital. Because of this limitation, the data in the OSCAR system available for this follow-up report lack the historical survey data used for the original study. Therefore, we used the OSCAR data pulled for the original inspection for years 1995, 1996, and 1997.

As with the previous inspection, this analysis looked only at short-term acute care hospitals, which represent 72 percent of nonaccredited hospitals. We did not include long-term care, rehabilitation, psychiatric or childrens' hospitals in our analysis so that we could make more accurate comparisons to our previous work. Furthermore, we did no analysis on the survey frequency of these other types of nonaccredited hospitals. States are responsible for surveying all nonaccredited

hospitals in the Budget Call Letter, and we recognize this as a limitation of our analysis.

Our analysis of hospital complaints is based on OSCAR data downloaded in February 2004. These data reflect complaints for all hospitals. Though not all complaints are entered into the OSCAR system, the system does contain all complaints that require States to conduct onsite surveys. For more detail on our OSCAR analysis, see Appendix A.

**Budget Call Letters.** We reviewed the Budget Call Letters from 1999 through 2004.

We conducted this inspection in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

### In 2003, States surveyed 79 percent of short-term acute care nonaccredited hospitals within 3 years compared with 50 percent in 1997

Our previous report showed that the percentage of short-term acute care nonaccredited hospitals States surveyed within 3 years fell from 72 to 50 percent between 1995 and 1997. In response to our original report, CMS committed to surveying all nonaccredited hospitals every 3 years, the same frequency as that established by the Joint Commission for accredited hospitals. In 2001, States surveyed 49 percent of short-term acute care nonaccredited hospitals within 3 years. This number grew to 62 percent in 2002, and 79 percent in 2003. Like our previous report, this analysis includes only short-term acute care nonaccredited hospitals, which represent 72 percent of nonaccredited hospitals.

The remaining 21 percent of short-term acute care nonaccredited hospitals that had not been surveyed within 3 years in 2003 lacked routine oversight to ensure that they meet Federal health and safety standards. Furthermore, 12 percent (80 hospitals) had not received a State survey within 5 years. Of the 44 States with short-term acute care nonaccredited hospitals in 2003, 29 States had at least 1 hospital that had not been surveyed in 3 years and 1 State had as many as 21 hospitals not surveyed within a 3-year timeframe.

### However, the national annual survey rate is too low to sustain this progress

The national annual survey rate reflects the number of short-term acute care nonaccredited hospitals surveyed each year divided by the total number of such hospitals in all 50 States in each fiscal year. To ensure that all short-term acute care nonaccredited hospitals are surveyed once every 3 years, at least 33 percent of hospitals should be surveyed each year over a 3-year period, assuming that the number of hospitals does not change and no hospital is surveyed more than once. In 2001, States surveyed 25 percent of short-term acute care nonaccredited hospitals nationally. The national annual survey rate grew to 28 percent in 2002. However, States surveyed only 21 percent of such hospitals in 2003. (See Table 1 on the following page.) Unless the national annual survey rate for short-term acute care nonaccredited hospitals increases, States will be unable to maintain a survey frequency that ensures that these hospitals are surveyed once every 3 years.

**Table 1. National Annual Survey Data: 2000-2003**
**Short-Term Acute Care Nonaccredited Hospitals**

| | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|
| National annual survey rates for short-term acute care nonaccredited hospitals | 19% | 25% | 28% | 21% |
| National annual number of short-term acute care nonaccredited hospital surveys | 196 | 231 | 212 | 134 |
| National number of short-term acute care nonaccredited hospitals | 1,044 | 908 | 766 | 640 |

Source: OIG analysis of OSCAR data and Budget Call Letters, 2004.

Several factors contributed to these declines in surveys for short-term acute care nonaccredited hospitals:

**Conversions to critical access hospitals necessitated additional surveys by State agencies.** The number of nonaccredited hospitals decreased from 1,361 to 640 between 1997 and 2003. During this period, many nonaccredited hospitals converted to critical access hospitals. Participating States can grant critical access hospital status to certain limited service rural hospitals that participate in the Rural Hospital Flexibility Program, which the Balanced Budget Act of 1997 established to promote health care delivery in rural areas. (See Appendix B for more detailed information.) Incentives exist for eligible nonaccredited hospitals to convert: cost-based reimbursement from Medicare, rather than prospective payment; partnerships with acute care hospitals for support and expansion of services; and capital improvement costs included when determining Medicare reimbursement.[9] Between calendar years (CY) 2000 and 2003, the number of critical access hospitals increased from 318 to 855.[10] Likewise, the number of States with such hospitals rose from 35 to 45 between CY 2000 and CY 2003.

These conversions add more surveys to States' already full workload. In the fiscal year (FY) 2001 Budget Call Letter, CMS calls for States to survey 33 percent of approved critical access hospitals annually, the same survey frequency as nonaccredited hospitals. CMS considers critical access hospitals the same priority level as

nonaccredited hospitals. However, CMS also requires an initial survey for each hospital that chooses to convert to a critical access hospital. In addition, CMS expects them to be resurveyed 1 year after their conversion survey.

**Other surveys take priority over nonaccredited hospital surveys.** Between FY 1997 and FY 2003, the number of hospital complaints that required an onsite survey at any hospital, accredited or nonaccredited, grew 79 percent, from 2,079 to 3,721. Responding to complaints and adverse events remains as high a priority among State survey and certification activities as it was in 1997. In CMS's FY 2003 Budget Call Letter, complaint surveys are given the highest priority after surveys of facilities with legislatively mandated survey cycles. This places complaint surveys at a higher priority than surveys of nonaccredited hospitals.

CMS also expects States to allocate resources to surveying facilities with legislatively mandated survey cycles before surveying nonaccredited hospitals. These mandated priorities for Medicare include annual certifications of nursing homes, certifications of home health agencies within 3 years, and validation surveys of accredited hospitals.[11] For Medicaid, they include annual certifications of nursing homes and annual certifications of intermediate care facilities for people with mental retardation. Nursing home surveys represent the largest and most predictable part of the States' survey workload. In 1998, States conducted 12,555 nursing home certification surveys. In 2001, this grew to just over 15,000 nursing home surveys, a 20 percent increase.[12]

**Budget Call Letter Language**. CMS committed to establishing a more frequent survey cycle for nonaccredited hospitals so that they would be surveyed with the same frequency that the Joint Commission accredits hospitals. Hospitals accredited by the Joint Commission are surveyed on a 3-year cycle, but CMS did not establish a 3-year survey cycle for nonaccredited hospitals. Rather, the CMS Budget Call Letter since 2001 has called for States to annually survey 33 percent of all nonaccredited hospitals, up from the previous rates of 15 percent in 1997 and 11 percent in 2000.[13] Though on the surface it might appear that this language is equivalent to a 3-year survey cycle, this is not the case. By repeatedly surveying some hospitals and not surveying others, it may be possible for States to consistently meet the 33 percent annual survey rate for their nonaccredited hospitals but at the same

time not survey all nonaccredited hospitals within 3 years. Resurveying the same nonaccredited hospitals may be appropriate in some cases to ensure safety and quality. However, the annual survey percentage called for in the Budget Call Letter does not account for such additional surveys in the annual 33 percent determination.

## SUMMARY

Certification and complaint surveys remain the principal way that CMS and State agencies can ascertain whether nonaccredited hospitals meet Federal health, safety, and program standards. While the percent of short-term acute care nonaccredited hospitals surveyed within 3 years has increased, the national annual survey rate has dropped and is now too low to sustain this progress. To ensure that all short-term acute care nonaccredited hospitals are surveyed once every 3 years, at least 33 percent of hospitals should be surveyed each year over a 3-year period, assuming that the number of hospitals does not change and no hospital is surveyed more than once.

## AGENCY COMMENTS

CMS agreed that recent survey rates make sustained improvement in the percent of short-term acute care nonaccredited hospitals surveyed within 3 years uncertain. It further noted that it has additional survey responsibilities and that resources are limited.

CMS identified adjustments it will make in response to our report. First, it will lower the priority of its earlier commitment to survey nonaccredited hospitals once every 3 years. It will also create a new, higher priority goal of surveying nonaccredited hospitals an average of every 4.5 years. Further, it will require States to target certain hospitals that are more likely to have systemic quality problems for more frequent surveys. Finally, it will add a performance standard for States to ensure that the top priority survey frequencies are met. For CMS's complete comments, see page 11 of this report.

## OIG RESPONSE

We are pleased that CMS agrees with our summary that although the percentage of short-term acute care nonaccredited hospitals surveyed within 3 years has improved, recent national annual survey rates raise concern that the improvement may not be sustainable. However, CMS also proposes changes to the survey commitment it made in response to the OIG's previous report (that it survey nonaccredited hospitals every 3 years, which is the same frequency as that of the Joint Commission).

We acknowledge that CMS faces resource limitations. However, we remain concerned that its adjustments could result in some nonaccredited

hospitals operating without a survey for considerable lengths of time. Because CMS proposes an *average* of 4.5 years between surveys, by definition the gap between surveys at some nonaccredited hospitals will exceed that length of time, and some could exceed it by a considerable number of years.

At the same time we appreciate the role that targeting some hospitals for more frequent surveys can serve in protecting Medicare beneficiaries. Furthermore, we also appreciate CMS's addition of performance standards for States.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

MAY 26 2005

**TO:** Daniel R. Levinson
Acting Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D
Administrator

**SUBJECT:** OIG Draft Report: "CMS Oversight of Short-term Acute Care Nonaccredited Hospitals" (OEI-01-04-00020)

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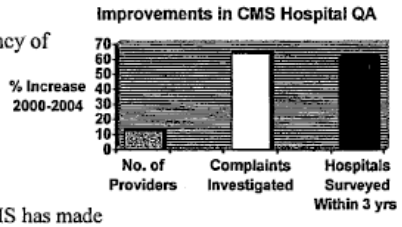
OFFICE OF INSPECTOR GENERAL

Thank you for the opportunity to review and comment on the above draft report from the Office of Inspector General (OIG). We appreciate the investment of time and expertise made by the OIG to assist us to continue to improve quality assurance in hospitals.

The OIG report finds considerable progress in increasing the percentage of non-accredited, short-stay (acute care) hospitals that are surveyed at least once every three years (from 50 percent in 1997 to 79 percent in 2003). The report also cautions that the most recent survey frequency rate (in 2003) is insufficient to sustain such progress over time.

The CMS has done more than just improve the frequency of hospital surveys. For example, we increased by 64 percent the complaint investigations conducted for all types of hospitals, as illustrated in this graph. These and other areas of progress compete for limited resources.




We therefore share both the OIG's conclusion that CMS has made substantial progress and the OIG's concern for the future. In the past two years, the survey and certification budget has been funded at levels either below the President's budget request (2005) or even below the prior year's level (2004). Such reduction indicates that Congress expects us to make appropriate adjustments to reconcile funding and policy. We also intend to redouble our current efforts to achieve maximum value for each taxpayer dollar expended. This means that, for the future, we will adopt more refined methods to assure quality, such as more targeted methods to conduct surveys rather than relying so extensively on the gross number of surveys conducted.

| Year | Amount of S&C Budget Reduction | |
|---|---|---|
| 2004 | $1,491,000 | Reduction from 2003 Actual Level |
| 2005 | $11,700,000 | Reduction from President's Request |

It is also worth observing that many types of hospitals are subject to CMS survey and/or complaint investigations. Each contributes to the workload challenge, and in each area CMS has made

improvements. The major hospital types are: accredited hospitals, nonaccredited hospitals, accredited critical access hospitals (CAHs) and nonaccredited CAHs, and psychiatric hospitals. Although all must be in compliance with the Federal requirements for health and safety, each of these hospital types is subject to slightly different survey frequency.

Accredited hospitals are deemed to meet the Federal requirements by virtue of their accreditation by either the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association. They are only subject to oversight surveys on a selective sample basis by CMS. However, CMS does investigate many complaints related to accredited hospitals, and removes the hospital's deemed status if we find the conditions of participation for Medicare have been violated.

Nonaccredited hospitals are subject to routine oversight surveys (approximately once every three to six years) to determine their compliance with the Federal requirement for health and safety. Such hospitals are also subject to survey in response to a complaint.

The CAHs are a relatively new type of hospital and may be either accredited or non-accredited. Nonaccredited CAHs are subject to oversight surveys upon initial conversion to CAH status, one-year following conversion to CAH status, and then on a routine schedule (approximately every three to five years).

Psychiatric hospitals are subject to CMS survey once every three to five years. There is no accreditation of the overall hospital that CMS accepts as conferring deemed status. CMS standard surveys of psychiatric hospitals have increased by about 61 percent from 2000 to 2004 and the number of complaints investigated has increased by about 96 percent.

The draft OIG report concerns only nonaccredited, acute care hospitals. It documents the extent to which the frequency of nonaccredited hospital surveys has improved since the 1999 OIG report. This report indicates that while there has been substantial improvement in the survey rate of these hospitals since 1999, CMS needs to survey at least 33 percent of them each year in order to meet the goal of ensuring that all nonaccredited hospitals are surveyed at least once every three years.

The above discussion of the various types of hospitals subject to survey is useful in appreciating that the data upon which both we and the OIG rely are subject to limitations of the current information system. In particular, the frequency of surveys may be understated. This is due to the fact that certain providers that switch categories during the year may be counted twice (once in each category). A non-accredited hospital that switches to accredited status at the beginning of the year may still show up in the statistics for non-accredited hospitals, implying that a state survey should have been conducted when a survey is not required.

In the remarks below we provide more specific comments to the draft report and our future direction.

**OIG Recommendation**

OIG found that "the percentage of short-term acute care nonaccredited hospitals surveyed within 3 years had improved from 50 percent to 79 percent between 1997 and 2003. However, the national annual survey rate (the number of short-term acute care nonaccredited hospitals surveyed each year divided by the total number of such hospitals) declined to 21 percent in 2003, from 28 percent in 2002 and 25 percent in 2001. To survey all such hospitals within 3 years, at least 33 percent of hospitals should be surveyed each year over a 3-year period assuming that no hospital is surveyed more than once and the number of hospitals remains the same."

**CMS Comments**

We appreciate OIG's acknowledgment in the report that considerable progress has been made toward increasing the frequency of surveys for non-accredited hospitals. This progress has occurred despite a 12 percent increase in the total number of hospitals from fiscal year (FY) 2000 through 2004, a 64 percent increase in the number of complaints investigated, and a 200 percent increase in the number of conversions to critical access hospital status (which requires more frequent surveys in the first two years following conversion).

While the agency's 1999 response to the earlier OIG study changed CMS policy to increase the frequency of surveys such that every non-accredited hospital would be surveyed every three years, and while considerable progress was made, neither the funding nor the infrastructure were fully implemented to ensure that such a goal was completely fulfilled.

Recent Congressional action funds the survey and certification budget at a level considerably lower than requested in the President's FY 2005 budget request. Such action indicates that Congress expects us to make appropriate adjustments to reconcile funding and policy, as well as redouble our current efforts to achieve maximum value for each taxpayer dollar expended.

We are therefore adopting a number of revisions to CMS policy to target scarce resources in the most effective manner and ensure that the targeted, priority surveys occur. These actions differ from the OIG report recommendations and from past (HCFA) policy that responded to the 1999 OIG report.

Hospital surveys currently represent a "tier 3" priority for states. Raising the priority level would increase the likelihood that the surveys will occur. Targeting more frequent surveys to those hospitals more likely to experience quality problems would make more efficient use of resources than scheduling every hospital for the same frequency of surveys. Based on these considerations, we will adopt the following adjustments:

1. ***Higher Priority***: Surveys of non-accredited hospitals will be raised from "tier 3" priority to "tier 2" (just below the number one priority of statutorily-required surveys) for surveying non-accredited hospitals an average of every 4.5 years; the remaining surveys needed to raise the frequency to once every 3 years will be made a "tier 4" priority.

2. ***Targeting:*** States will be required to use available data (e.g. complaint data, recent history, survey deficiency data, and corrective action information) to target more frequent surveys to

those hospitals that are more likely to exhibit systemic quality problems compared to others. Some hospitals will be surveyed every six years while other hospitals will be surveyed much more frequently, to achieve a once every four year average. In this way survey and certification resources will be targeted to those hospitals needing the most attention.

3. ***Performance Fulfillment:*** We will add a performance standard and appropriate follow-up mechanisms to assure that the expected, top priority survey frequencies are met. Such a standard and follow-up mechanisms were not put into place after the 1999 OIG report.

**OSCAR Data.** We included short-term acute care nonaccredited hospitals participating in Medicare on the first day of each FY in our analysis. To further refine the list of active nonaccredited short-term acute care hospitals, we removed data on certain hospitals from OSCAR: those listed in OSCAR as leaving the program before the first day of the FY; those that entered the Medicare program after the first day of the FY accredited; those accredited by the Joint Commission; those that were located in U.S. territories; and those that did not bill Medicare for 2 consecutive years. (See Table 2 above.)

**Table 2. Short-term Acute Care Nonaccredited Hospitals Dropped from Dataset**

| Fiscal Year | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|
| **Original Nonaccredited Hospital Count** | **1,908** | **1,908** | **1,908** | **1,908** |
| Nonaccredited hospitals that left program before 1st day of given fiscal year | 609 | 779 | 941 | 1,099 |
| Nonaccredited hospitals that entered program after 1st day of given fiscal year | 185 | 151 | 128 | 96 |
| Joint Commission accredited | 43 | 44 | 46 | 47 |
| U.S. territories | 23 | 24 | 24 | 23 |
| Hospitals that did not bill Medicare for 2 years | 4 | 2 | 3 | 3 |
| **Final Nonaccredited Hospital Count** | **1,044** | **908** | **766** | **640** |

Source: OIG analysis of OSCAR and CMS Customer Information System data, 2004.

We used FYs to determine the annual number of hospitals and the elapsed time since their most recent surveys. Annual nonaccredited hospital totals for each FY reflect hospitals listed in OSCAR as active on the first day of each FY. Elapsed time since each hospital's most recent survey reflects the time between October 1st of the relevant FY and the most recent prior survey.

We removed hospitals that were listed on the Joint Commission's Web site as accredited and that went 5 or more years without a survey.

We compared our FY lists of active hospitals against CY billing data from the CMS Customer Information System (HCIS). If a hospital on the OSCAR list had not billed Medicare in 2 years, the hospital was removed from the list. We checked our active nonaccredited hospital lists from

OSCAR for FYs 2000 through 2003 against HCIS billing data for CYs 1998 through 2002.

# APPENDIX ~ B

### Critical Access Hospitals

States can designate critical access hospitals (CAH) as those limited-service hospitals participating in a program developed to strengthen rural health providers. A hospital can convert to CAH status if the State in which it is located has a Medicare Rural Flexibility Program approved by CMS. Under this program, a hospital that meets the State CAH eligibility requirements can convert to CAH status through a State survey or through accreditation.

CMS requires CAHs to meet a more limited set of conditions of participation compared to those of hospitals. Upon converting to CAHs, facilities also receive different provider numbers to reflect the CAH designation. CMS requires an initial survey for each hospital that chooses to convert to a CAH. A 1-year follow-up survey will occur to ensure continued compliance with the conditions of participation. After this followup, the CAH will be on the same survey cycle as other nonaccredited hospitals, 33 percent annually.

Hospitals that do convert to CAH status receive cost-based reimbursement, as well as other financial incentives. The CAHs are required to enter into agreements with a larger hospital. The program was intended to strengthen rural health care by encouraging the development of stronger networks for the provision of health care in rural areas.

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# END NOTES

[1] Zhan, Chunliu and Miller, Marlene. Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization. *Journal of the American Medical Association*. 2003; 290:1867-1874.

[2] Lamb, RM, Studdert, D, Bohmer, R., Berwick, D, and Brennan, T. Hospital Disclosure Practices: Results of a National Survey. *Health Affairs*. 2003; 22: 73-83.

[3] Hospital Conditions of Participation: 42 CFR §§ 482.11-482.13; 42 CFR §§ 482.21-482.45; 42 CFR §§ 482.51-482.57. These cover basic hospital functions, including staffing and clinical services, as well as administrative concerns, such as compliance with Federal, State, and local laws.

[4] Pursuant to the *Social Security Act*, hospitals are deemed to be in compliance with the conditions of participation with either the Joint Commission or American Osteopathy Association accreditation. (42 USC § 1395bb).

[5] Institute of Medicine. Medicare: A Strategy for Quality Assurance, Volume I. Washington, D.C.: National Academy Press, 1990.

[6] Hospital Conditions of Participation: 42 CFR §§ 482.11-482.13; 42 CFR §§ 482.21-482.45; 42 CFR §§ 482.51-482.57.

[7] Centers for Medicare & Medicaid Services. State Operations Manual (CMS-Pub. 7).

[8] Ibid.

[9] Rural Assistance Center: www.raconline.org/info_guides/hospital/cahfaq.php.

[10] This total includes both nonaccredited critical access hospitals and accredited critical access hospitals listed in HCIS that billed Medicare in CYs 2000 and 2003.

[11] CMS FY 2004 State Survey and Certification Budget Call Program Requirements and Budget Guidelines.

[12] Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections. *Nursing Home Deficiency Trends and Survey and Certification Process Consistency*. OEI-02-01-00600. March 2003.

[13] The Budget Call Letters do not specify a dollar amount to accomplish this task, nor do States account for the funds by survey type. Therefore, it is difficult to assess if States received sufficient funds to meet this guideline.